

# SHARED WORK PLAN APPLICATION

K-BEN 101 (Rev. 11-10)

**RETURN TO:** Shared Work Program  
401 SW Topeka Boulevard  
Topeka, KS 66603-3182  
FAX: (785) 296-4269

Return this completed application as directed above. A determination of your company's eligibility to participate in the Shared Work Program will be made and you will be notified by letter.

**PRINT CLEARLY – use BLACK INK**

## A EMPLOYER INFORMATION

Company name:  Employer Serial Number:   
   
Preferred mailing address: Street OR P.O. Box Number  City   
State:  Zip +4:   Phone:   
Affected Unit:  Number of workers:  Number of affected workers:   
Regular work hours per week:  Plan to reduce hours from:  % to  %  
Will reduction in hours affect participating employees' fringe benefits? ☐ YES ☐ NO If YES, explain:

## B EMPLOYER CERTIFICATION (To be completed by the person authorizing the implementation of the program)

I certify that the implementation of this Shared Work Plan and the resulting reduction in work hours is in lieu of temporary layoffs that affect at least 10% of the affected unit. I have provided a list identifying the affected employees by name and Social Security number. I understand that during the time the Shared Work Plan is in effect, the Kansas Department of Labor (KDOL) will submit a list of those employees in the affected unit to me weekly. I am responsible for completing the form and submitting it directly to KDOL every week hours are reduced. By submitting this form electronically, I certify I am responsible for the information.

Printed name:  Title:   
Employer or representative signature:   
Date (mm dd yyyy):  E-mail:

## C COLLECTIVE BARGAINING INFORMATION (If there is such an agreement, to be completed by bargaining unit)

Union name:  Local number:   
Union official:  Title of official:   
Signature:  Date (mm dd yyyy):

### FOR AGENCY USE ONLY

Application received:  Employer current? ☐ YES ☐ NO Initials  Date:   
Reduced weekly hours:  Normal weekly hours:  Payroll week ending:   
Determination: ☐ Denied ☐ Approved Beginning date:  Ending date:   
Reason for denial:   
Examiner:  Date:  PLAN NO.  SUB PLAN NO.

